

**PATIENT**

Sophie Wisniewski

**SPECIES**

Canine

**BREED**

Airedale Terrier

**SEX**

Spayed Female

**AGE**

3 Years

**WEIGHT**

30.8 kg

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**IMAGING PERFORMED BY**

Sarah Pender, CVT

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**

Dr. Sevde- WVRC

**INVOICE**

16591

**DATE**

7/29/22

**PRESENTING CLINICAL SIGNS**

History: Sophie was originally doing well with her treatment for IMHA. Owner had started to wean the steroids per rDVM instructions. Yesterday Sophie was playing with her housemate and was fine. She was suddenly lethargic and not wanting to do much. Owner's report that it was a dramatic decline. Sophie was seen at her pDVM today. The primary recommended that Sophie be transferred here for a blood transfusion. No treatments were done today at pDVM. Sophie has no other pertinent medical history Current medications: Prednisone 10mg once daily (prednisone is being tapered down)

Abnormal PE/Chem/CBC/UA Results: On presentation to pDVM she was tachycardic at 180, had pale gums and was lethargic. CBC: HCT 13.9 (L), HGB 4.2 (L), MCHC 30.2, EOS 0.01 (L), PLT 120 (L), Retic 78.5 K/ul (N) ---- non-regenerative anemia CHEM: GLOB 3.5

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.3 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Left kidney is normal is size (7.52 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (7.11 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 0.41 cm at the cranial pole and 0.38 cm at the caudal pole. The right adrenal gland measures 0.6 cm at the cranial pole and 0.32 cm at the caudal pole.

**Spleen**

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal. An approximate 1.0 cm in diameter iso- to slightly hypoechoic bulge is present near the head of the spleen.

**Liver**

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

**Gastrointestinal**

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

***Pancreas*****SEX**

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

***Free Abdomen*****AGE**

3 Years

There is no evidence of peritoneal effusion.

The mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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**ULTRASONOGRAPHIC FINDINGS****Primary Findings**

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Small/flattened adrenal glands, as expected with the reported historical and current steroid administration.

**Secondary Findings**

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely given the location and diffuse nature of the changes.
- Reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the relapse of the reported immune mediated hemolytic anemia during prednisone taper, recommendations are to consider adding a second immunosuppressant in addition to reincreasing the prednisone temporarily with the goal of the second immunosuppressant, allowing future tapering of prednisone.

If not recently evaluated, comprehensive infection disease testing is recommended.

Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration

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is recommended.

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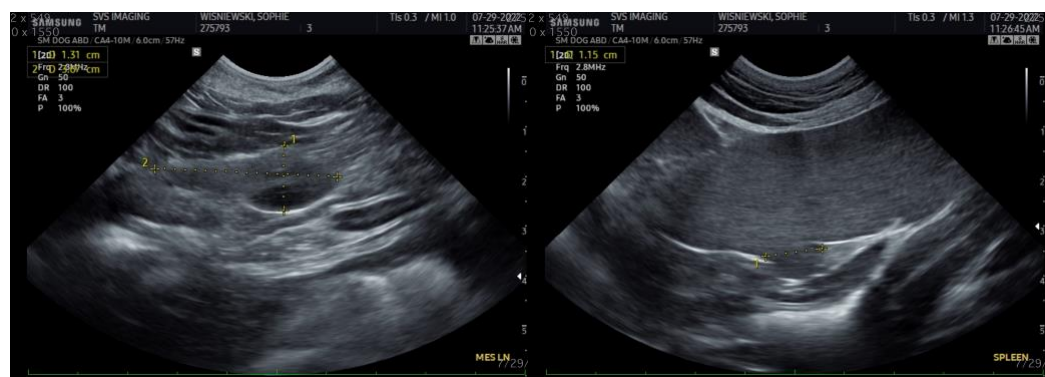
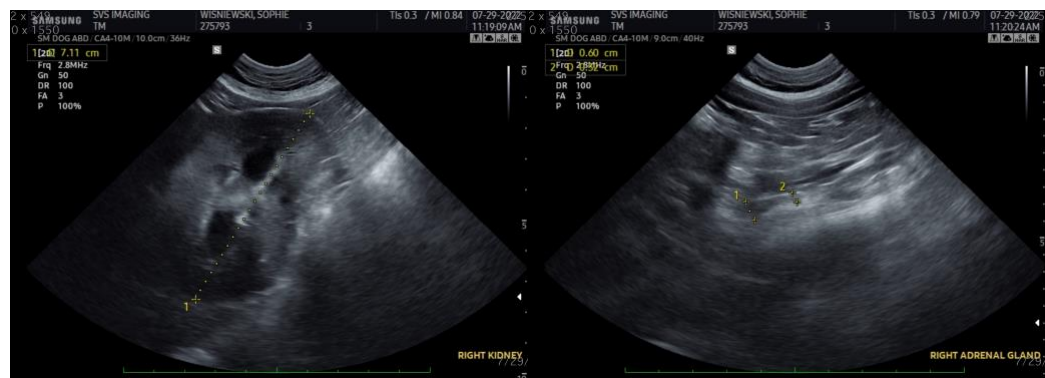
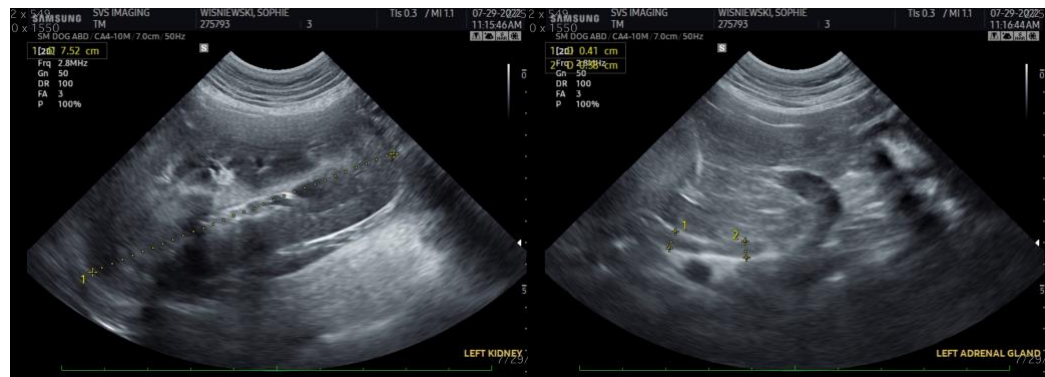
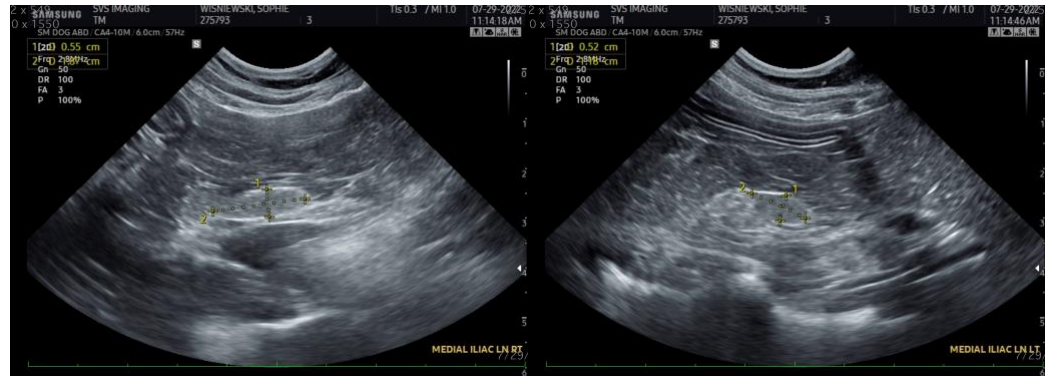
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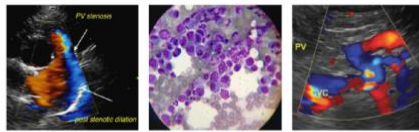
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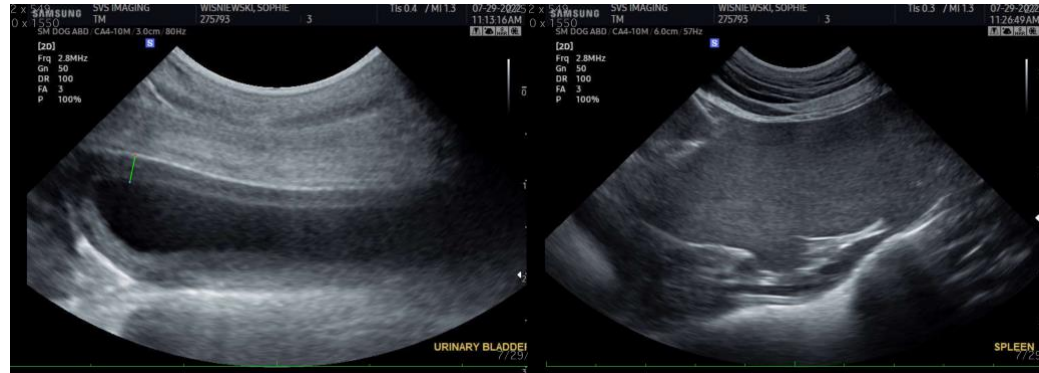
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

**Beth Johnson, DVM DACVIM**

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